

Department of Health and Human Services Public Health Service Small Business Innovation Research Program Phase I Grant Application <i>Follow instructions carefully.</i>		Leave blank — for PHS use only. <table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 33%;">Type</td><td style="width: 33%;">Activity</td><td style="width: 33%;">Number</td></tr><tr><td colspan="2">Review Group</td><td>Formerly</td></tr><tr><td colspan="2">Council Board (Month, year)</td><td>Date Received</td></tr></table>		Type	Activity	Number	Review Group		Formerly	Council Board (Month, year)		Date Received
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Review Group		Formerly										
Council Board (Month, year)		Date Received										
1. TITLE OF APPLICATION (Do not exceed 56 typewriter spaces)												
2. SOLICITATION NO. PHS 97-2												
3. PRINCIPAL INVESTIGATOR <input type="checkbox"/> New Investigator												
3a. NAME (Last, first, middle)		3b. DEGREE(S)	3c. SOCIAL SECURITY NO. Provide on Personal Data Page.									
3d. POSITION TITLE		3e. MAILING ADDRESS (Street, city, state, zip code)										
3f. TELEPHONE AND FAX (Area code, number, and extension) TEL: FAX:		BITNET/INTERNET Address:										
4. HUMAN SUBJECTS <input type="checkbox"/> NO <input type="checkbox"/> YES	4a. If "yes," Exemption no. <input type="checkbox"/> or <input type="checkbox"/> IRB approval date <input type="checkbox"/> <input type="checkbox"/> Full IRB or Expedited Review	4b. Assurance of compliance no. <input type="checkbox"/>	5. VERTEBRATE ANIMALS <input type="checkbox"/> NO <input type="checkbox"/> YES									
		5a. If "Yes," IACUC approval date <input type="checkbox"/>	5b. Animal welfare assurance no. <input type="checkbox"/>									
6. DATES OF PROJECT PERIOD From: Through:		7. COSTS REQUESTED 7a. Direct Costs \$ 7b. Total Costs \$										
8. PERFORMANCE SITES (Organizations and addresses)		9. APPLICANT ORGANIZATION (Name and address of applicant small business concern)										
		10. ENTITY IDENTIFICATION NUMBER	Congressional District									
		11. SMALL BUSINESS CERTIFICATION <input type="checkbox"/> Small Business Concern <input type="checkbox"/> Women-owned <input type="checkbox"/> Socially and Economically Disadvantaged										
12. NOTICE OF PROPRIETARY INFORMATION: The information identified by asterisks(*) on pages of this application constitutes trade secrets or information that is commercial or financial and confidential or privileged. It is furnished to the Government in confidence with the understanding that such information shall be used or disclosed only for evaluation of this application, provided that, if a grant is awarded as a result of or in connection with the submission of this application, the Government shall have the right to use or disclose the information herein to the extent provided by law. This restriction does not limit the Government's right to use the information if it is obtained without restriction from another source.		14. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name: Title: Address: Telephone: FAX: BITNET/INTERNET Address:										
13. DISCLOSURE PERMISSION STATEMENT: If this application does not result in an award, is the Government permitted to disclose the title only of your proposed project, and the name, address, and telephone number of the official signing for the applicant organization, to organizations that may be interested in contacting you for further information or possible investment? <input type="checkbox"/> YES <input type="checkbox"/> NO												
15. PRINCIPAL INVESTIGATOR ASSURANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.		SIGNATURE OF PERSON NAMED IN 3a (In ink. "Per" signature not acceptable.)	DATE									
16. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Service terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.		SIGNATURE OF PERSON NAMED IN 14 (In ink. "Per" signature not acceptable.)	DATE									

Principal Investigator (*Last, first, middle*): _____

Abstract of Research Plan

NAME, ADDRESS, AND TELEPHONE NUMBER OF APPLICANT ORGANIZATION

YEAR FIRM FOUNDED

NO. OF EMPLOYEES (*include all affiliates*)

TITLE OF APPLICATION

KEY PERSONNEL ENGAGED ON PROJECT

NAME	ORGANIZATION	ROLE ON PROJECT
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ABSTRACT OF RESEARCH PLAN: State the application's broad, long-term objectives and specific aims, making reference to the health-relatedness of the project. Describe concisely the research design and methods for achieving these goals and discuss the potential of the research for technological innovation. Avoid summaries of past accomplishments and the use of the first person. This abstract is meant to serve as a succinct and accurate description of the proposed work when separated from the application. If the application is funded, this description, as is, will become public information. ***Therefore, do not include proprietary or confidential information.*** DO NOT EXCEED 200 WORDS.

Provide key words (8 maximum) to identify the research or technology.

Provide a brief summary of the potential commercial applications of the research.

Budget for Phase I—Direct Costs Only					FROM	TO	
PERSONNEL <i>(Applicant organization only)</i>		Type Appt. <i>(months)</i>	% Effort on Project	Institutional Base Salary	DOLLAR AMOUNT REQUESTED <i>(omit cents)</i>		
NAME	Role on Project				Salary Requested	Fringe Benefits	TOTALS
SUBTOTALS →							
CONSULTANT COSTS							
EQUIPMENT <i>(Itemize)</i>							
SUPPLIES <i>(Itemize by category)</i>							
TRAVEL							
PATIENT CARE COSTS		Inpatient					
		Outpatient					
CONTRACTUAL COSTS							
OTHER EXPENSES <i>(Itemize by category)</i>							
TOTAL DIRECT COSTS <i>(Also enter on Face Page, Item 7a)</i> →							\$
FIXED FEE REQUESTED							\$

OTHER SUPPORT *(see instructions)* ☐ NO ☐ YES

Budget Justification

Using continuation pages if necessary, describe the specific functions of the personnel and consultants. Read the instructions and justify costs accordingly.

Resources

FACILITIES: Specify the facilities to be used for the conduct of the proposed research. Indicate their capacities, pertinent capabilities, relative proximity, and extent of availability to the project. Include laboratory, clinical, animal, computer, and office facilities at the applicant small business concern and any other performance site listed on the FACE PAGE. Identify support services such as secretarial, machine shop, electronics shop, and the extent to which they will be available to the project. Use continuation page(s) if necessary.

MAJOR EQUIPMENT: List the most important equipment items already available for this project, noting the location and pertinent capabilities of each.

Checklist

TYPE OF APPLICATION (Check appropriate box[es].)

- ☐ NEW application. (This application is being submitted to the Public Health Service for the first time.)
- ☐ REVISION of previously-submitted application number _____
(This application replaces a prior unfunded version of a new application.)
- ☐ CHANGE of Principal Investigator (if applicable)
Name of former Principal Investigator _____

1. ASSURANCES/CERTIFICATIONS

The assurances/certifications set forth below are made and verified by the signature of the OFFICIAL SIGNING FOR APPLICANT ORGANIZATION (small business concern) on the FACE PAGE of the application. Descriptions of individual assurances/certifications are found in application instructions under "**Checklist**." If unable to certify compliance with any item, provide an explanation and place it after this page.

• Human Subjects; • Vertebrate Animals; • Debarment and Suspension; • Drug-Free Workplace; • Delinquent Federal Debt; • Research Misconduct; • Civil Rights (Form HHS 690); • Handicapped Individuals (Form HHS 690); • Age Discrimination (Form HHS 690).

2. PROGRAM INCOME (See discussion in application instructions under "**Checklist**.")

All applications must indicate (Yes or No) whether program income is anticipated during the period for which grant support is requested.

- ☐ No ☐ Yes (If "Yes," use the format below to reflect the amount and source(s) of anticipated program income.)

Budget Period	Anticipated Amount	Source(s)

3. INDIRECT COSTS (See discussion in application instructions under "**Checklist**.")

Insert the rate, if known. If the applicant organization does not have a currently negotiated rate with the Department of Health and Human Services (DHHS) or another Federal agency, it must estimate the amount of indirect costs allocable (applicable) to the proposed Phase I project. That amount should be inserted in the space provided below. The

applicant organization should also be prepared to furnish financial documentation to support the estimated amount, if requested by the Public Health Service. An applicant organization may elect to waive indirect costs if it so desires.

- ☐ DHHS agreement, dated: _____ . _____ % salary and wages or _____ % Total Direct Costs.
- ☐ No DHHS agreement, but rate established with _____, dated: _____
- ☐ Rate negotiation pending with the National Institutes of Health.
- ☐ Indirect costs allocable (applicable) to this Phase I project are estimated to be \$ _____
- ☐ No indirect costs requested.

4. SMOKE-FREE WORKPLACE

Does your organization currently provide a smoke-free workplace and/or promote the non-use of tobacco products or have plans to do so?

- ☐ Yes ☐ No (The response to this question has no impact on the review or funding of this application.)

Place this form at the end of the signed original
copy of the application. Do not duplicate.

Social Security No. _____

PERSONAL DATA ON PRINCIPAL INVESTIGATOR

The Public Health Service (PHS) has a continuing commitment to monitor the operation of its review and award processes to detect—and deal appropriately with—any instances of real or apparent inequities with respect to age, sex, race, or ethnicity of the proposed principal investigator.

To provide the PHS with the information it needs for this important task, complete the form below and attach it to the signed original of the application after the Checklist. **Do not attach copies of this form to the duplicated copies of the application.**

Upon receipt of the application by the PHS, this form will be separated from the application. This form will **not** be duplicated, and it will **not** be a part of the review process. Data will be confidential, and will be maintained in Privacy Act record system 09-25-0036, "Grants: IMPAC (Grant/Contract Information)." The PHS requests Social Security Numbers for accurate identification, referral, and review of applications and for management of PHS grant programs. Provision of the Social Security Number is voluntary. No individual will be denied any right, benefit, or privilege provided by law because of refusal to disclose his or her Social Security Number. The PHS requests the Social Security Number under Sections 301(a) and 487 of the PHS Act as amended (42 USC 241a and USC 288). All analyses conducted on the date of birth and race and/or ethnic origin data will report aggregate statistical findings only and will not identify individuals.

If you decline to provide this information, it will in no way affect consideration of your application.

Your cooperation will be appreciated.

DATE OF BIRTH (MM/DD/YY)

GENDER

☐

Female

☐

Male

RACE AND/OR ETHNIC ORIGIN (check one)

Note: The category that most closely reflects the individual's recognition in the community should be used when reporting mixed racial and/or ethnic origins.

- ☐ **American Indian or Alaskan Native.** A person having origins in any of the original peoples of North America, and who maintains a cultural identification through tribal affiliation or community recognition.
- ☐ **Asian or Pacific Islander.** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
- ☐ **Black, not of Hispanic origin.** A person having origins in any of the black racial groups of Africa.
- ☐ **Hispanic.** A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- ☐ **White, not of Hispanic origin.** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- ☐ Check here if you do not wish to provide some or all of the above information.